ACTA MEDICA-IRANICA
Vol.28.1986.P.85

RECURRENT SUBCLITORAL ABSCESS TREATED BY MARSUPIALIZATION

HORMOZ DABIRASHRAFI*.M.D.
SIMIN KAMYAB TEHRANY.*M.D.

SUMMARY:

This is a report of a very rare case of recurrent subclitoral abscess. Its etiology and the best treatment of the disease is here in discussed. We, the same as Sur, believe that marsupialization is the most promising treatment.

Recurrent periclitoral abscess has been described previously[5].Some of the authors believe that it is part of the pilonidal disease. The first pilonidal cyst in the clitoral region was introduced by Palmer[7](1957). Another case of pilonidal sinus of clitoris was reported by Betson[2]. All of the researchers are not in this opinion that the disease is necessarily a pilonidal sinus[13],and, sometimes, there is not any hair in the epithelium lining of the cyst.

One case of recurrent subclitoral abscess treated by marsupialization is presented here.

CASE REPORT:

* Assistant Professor of Obstetrics and Gynecology. at University of Tehran(Mirza Kouchek Khan Hospital)

F.N.a 42 years old, Gravida 10, para 10,house wife came to the hospital with pain in external genitalia. Her previous history was normal except for a DxC,because of polymenorrhea. Her history of pain, oedema and discharge from external genitalia goes back to fifteen years ago. From then the course of illness was swelling with pain and discharge and then relief of pain, which repeated every two years. From eight months ago the cycle has become every two months. She stated that in every cycle a small painful lump had developed without obvious cause in the subclitoral region just to the left of midline, slowly, enlarged, and eventually discharged thick yellow pus. Three months ago she was operated by a General surgeon. The report of operation is as follows:a canal bellow the clitoris was found and excised". The pathology report showed: "The lining of epithelial cells,with no sign of malignancy, and without hair in the surface".

At physical examination, bellow the clitoris a hard mass about two centimeters in diameter was found which was tender to touch and was thought to be a small abscess(Fig. 1).A scabbed over orifice was present on the top of abscess. The patient was admitted to the hospital with the diagnosis of "Recurrent subclitoral abscess."

The serologic tests for syphilis were nonreactive. Cytologic smear showed no evidence of malignancy.Fasting blood suger and two hours post prandial glucose concentrations were normal. PPD skin test and chest X-Ray all were normal. Sedimentaiton rate for one and two hours was 47 and 76 Respectively. The other routine tests were in the normal range.

The patient was prepared for marsupialization.Under

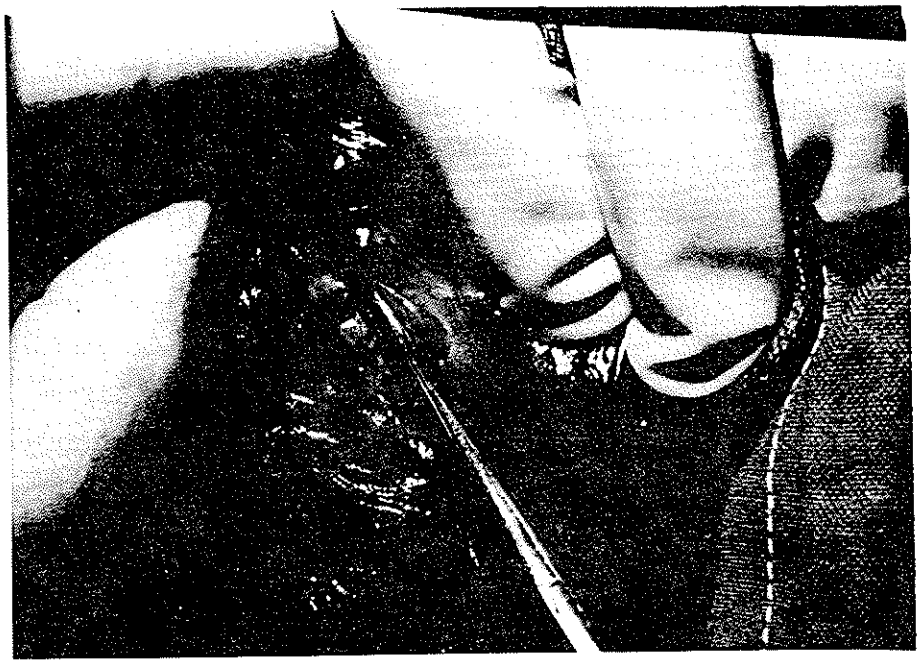

Fig.1- Subclitoral abscess.
(on the top of artery forceps)

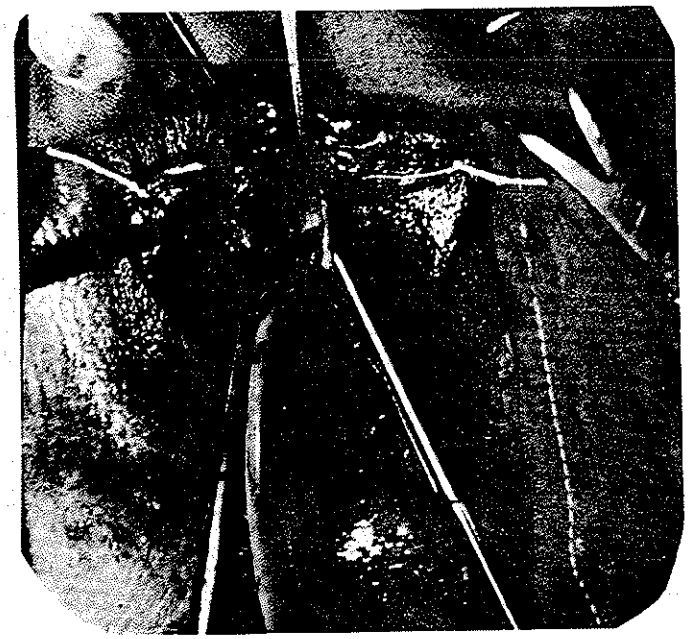

Fig. 2- The duct of abscess.

general anesthesia, the surface of the abscess was opened, after extrusion of the pus a sinus tract was appeared below the clitoris in the length of about 3-4 cm (Fig. 2-3). Marsupialization was done and the sinus was laid open (Fig. 4). The pus from the abscess cavity was sent to be cultured. The Result of aerobic culture was negative. Animal culture for tuberculosis was not performed, because, in the previous cycle of "pain, swelling, and discharge" before present operation, the inflammation generally responded fairly well to Antibiotices.

The postoperative course was uneventful and healing was rapid. Since the operation (nearly one year ago),the patient has had no complaints and no recurrence of the abscess.

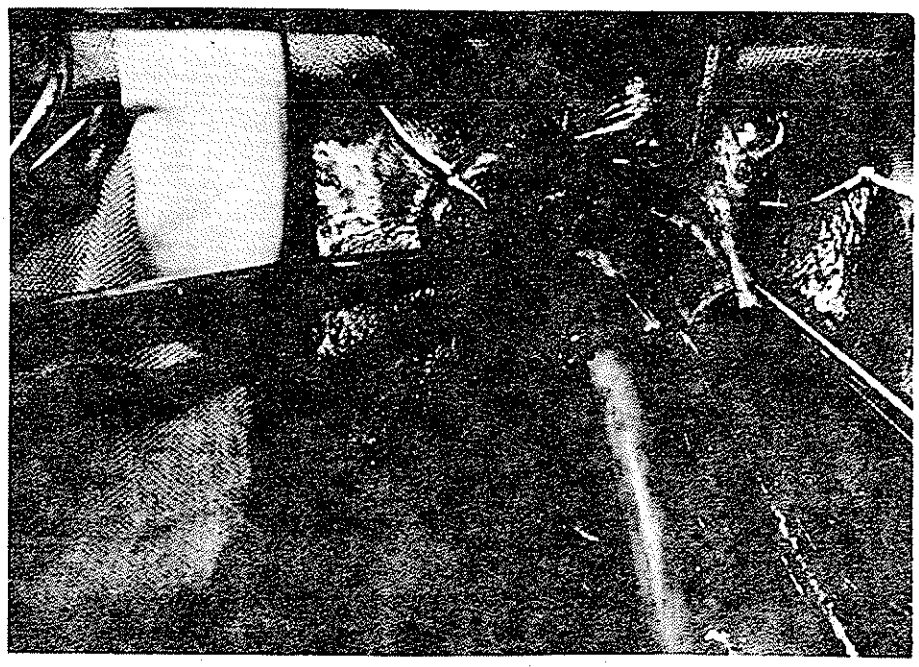

Fig. 3- The duct of abscess.

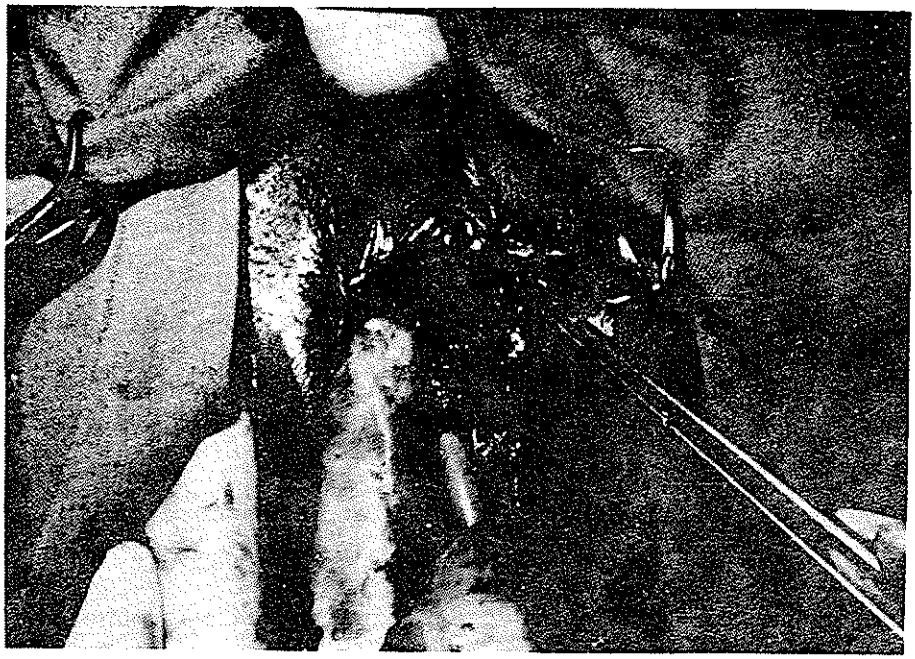

Fig.4-Marsupialization operation.

COMMENT:

Hodges (1830) used the term "pilonidal" and was one of the first to view the lesion as congenital in origin. Although, the earliest description of this entity appeared in 1847 by Anderson and in 1854 by Warren. The neurogenital view point developed logically from numerous studies of the embryologic development of the region by Gage[4], whose work largely governed the opinions and reports of others for many years thereafter. Fox [3] considered the lesion as a congenital defect of ectodermal origin, but in 1946 and later in 1948, Patey.[8-9] described identical lesion on barbers hands and this observation then seriously raised the question on the validity of the congenital origin. In the beginning, it was generally believed that pilonidal sinus was located almost exclusively at the sacral area, and had congenital (neurogenital) origin. But the disease has now been recorded in several situations- eg., the interdigital cleft of barbers (Patey)[8-9], the axilla (Aird[1]),the umbilicus (Patey[10]), the penis (Smith[14]) and the clitoris(Macleod [6]; in which a congenital origin is either impossible or unlikely. In simple word, according to acquired theory: a hair introduced into a skin cleft is subjected to a rubbing motion could erode through the skin and form a sinus tract. The persistence of the foreign body reaction to the hair allows the sinus tract to remain open. The sinus tract of cyst may become infected, intermittently heal, and then spontaneously break down and temporarily spill forth its contents". But, if pilonidal sinus has

an acquired origin, why we can not find it commonly on the hairy area of the body (for example pubic area). Patey[11], couldn't find any case of pilonidal sinus of scapl. On the other hand, pilonidal sinus of the cervix (with many hair in the sinus) have been reported[12], where from the point of histology is naturally without hair. In view of these facts the congenital theory will be put on again:"Is not the origin of pilonidal cyst from the remnant of ectoderm that has the potentiality of transformation and producing hair?"

In any case, we have to tell that, the etiology of these entities(pilonidal cyst) is still unknown. Up to now, 8 cases of pilonidal sinus of clitoris have been reported in surgical literature. However, Kent[5] reported four cases of recurrent periclitoral abscess without the pathologic signs of pilonidal sinus(without hair), and another two cases were added by Sur[13]. Present case report appeares to be like the Kent and Sur cases. In the pathological report of our case there were not any signs of hair. Some aspects of our patient were interesting:

1. The history of recurrent subclitoral abscess from fifteen years ago(that shows our physicians are not familiar with this disease).

2. The patient was not cured with local excision(by general surgeon), but felt well with marsupialization (Sur believes that irrespective of etiology and pathology, the ideal and most pormising treatment of periclitoral abscess is marsupialization. On the other hand, Betson[2] thinks when this condition is suspected, surgical extirpation should be deferred until the acute inflamma-

tory process has subsided. A prerequisite for operation success as with any sinus tract or cystic structure is meticulous removal of the entire structure), but there is no recommendation for local (incomplete) excision.

3. The orifice of the abscess in our patient was below the clitoris, while, in the cases of Kent and Sur the clitoris was inside the abscess. For this reason we called this case "Recurrent subclitoral abscess".

REFERENCES:

1- Aird, I.: Brit. M.J. 1: 902, 1952.
2- Betson. J.R.: Am. J. Obstet. Gynecol. 84:543,1962.
3- Fox, S.L.: Surg. Gynec. Obstet. 60: 137, 1935.
4- Gage, M.: Arch. Surg. 31: 175, 1935.
5- Kent, S.W.: Am. J. Obstet. Gynecol. 142: 355,1982.
6- Macleod, R.G.: Brit. Med. J.1: 710, 1953.
7- Palmer, E.: Am. J. Surg. 93: 133, 1957.
8- Patey, D.H.: Lancet. 2: 484, 1946.
9- Patey, D.H.: Lancet. 2: 13, 1948.
10-Patey, D.H. : Lancet. 2: 281, 1956.
11-Patey, D.H.: Lancet, March 24, 620, 1962.
12-Radman, H.M.: Am. J. Obstet. Gynecol September 15, 114 271, 1972.

13-Sur, S.: Am.J. Obstet. Gynecol 147: 340, 1983.

14-Smith, T.E.: J.A.M.A. 136: 973, 1956.